

106TH CONGRESS  
1ST SESSION

# S. 1725

To amend title XVIII of the Social Security Act to modernize medicare supplemental policies so that outpatient prescription drugs are affordable and accessible for medicare beneficiaries.

---

## IN THE SENATE OF THE UNITED STATES

OCTOBER 14, 1999

Mr. JEFFORDS introduced the following bill; which was read twice and referred to the Committee on Finance

---

## A BILL

To amend title XVIII of the Social Security Act to modernize medicare supplemental policies so that outpatient prescription drugs are affordable and accessible for medicare beneficiaries.

1       *Be it enacted by the Senate and House of Representa-*  
2       *tives of the United States of America in Congress assembled,*

3       **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

4       (a) **SHORT TITLE.**—This Act may be cited as the  
5       “DrugGap Insurance for Seniors Act of 1999”.

6       (b) **TABLE OF CONTENTS.**—The table of contents of  
7       this Act is as follows:

Sec. 1. Short title; table of contents.

Sec. 2. Findings and purposes.

Sec. 3. Modernization of medicare supplemental benefit packages.

- Sec. 4. Assistance to qualified low-income medicare beneficiaries.  
Sec. 5. Grandfathering of current Medigap enrollees.  
Sec. 6. Health insurance information, counseling, and assistance grants.  
Sec. 7. NAIC study and report.

1 **SEC. 2. FINDINGS AND PURPOSES.**

2 (a) FINDINGS.—Congress finds the following:

3 (1) Coverage of outpatient prescription drugs is  
4 the most important aspect of medical care not cur-  
5 rently provided under the medicare program under  
6 title XVIII of the Social Security Act.

7 (2) The medicare program needs to be re-  
8 formed, and should include provisions that provide  
9 access to outpatient prescription drugs for all medi-  
10 care beneficiaries.

11 (3) Comprehensive medicare reform will require  
12 extensive time and effort, but Congress must act  
13 now to provide outpatient prescription drug coverage  
14 to the most vulnerable medicare beneficiaries until  
15 such time as the medicare program is reformed.

16 (4) Low-income medicare beneficiaries are the  
17 most vulnerable to the high cost of outpatient pre-  
18 scription drugs, since they are often not eligible to  
19 receive benefits under medicaid, yet have incomes  
20 too low to afford medicare supplemental policies that  
21 include coverage for outpatient prescription drugs.

22 (5) Medicare beneficiaries deserve meaningful  
23 choices among medicare supplemental policies, in-

1 including the option of purchasing affordable out-  
2 patient prescription drug-only medicare supple-  
3 mental policies.

4 (6) Premiums for medicare supplemental poli-  
5 cies have risen dramatically in recent years, and  
6 steps must be taken to keep premiums from rising  
7 out of the reach of medicare beneficiaries.

8 (7) Increased use of medicare supplemental  
9 policies does not represent sufficient structural medi-  
10 care reform.

11 (b) PURPOSES.—The purposes of this Act are as fol-  
12 lows:

13 (1) To provide medicare supplemental policies  
14 covering outpatient prescription drugs to low-income  
15 medicare beneficiaries at no cost.

16 (2) To provide expanded choice to all medicare  
17 beneficiaries by creating affordable drug-only medi-  
18 care supplemental policies.

19 (3) To ensure that medicare supplemental poli-  
20 cies are modernized in a manner that promotes com-  
21 petition and preserves affordability for all medicare  
22 beneficiaries.

1 **SEC. 3. MODERNIZATION OF MEDICARE SUPPLEMENTAL**  
 2 **BENEFIT PACKAGES.**

3 (a) ADDITION OF DRUGGAP POLICIES AND MODI-  
 4 FICATION OF EXISTING MEDIGAP POLICIES.—Section  
 5 1882 of the Social Security Act (42 U.S.C. 1395ss) is  
 6 amended by adding at the end the following:

7 “(v) MODERNIZED BENEFIT PACKAGES FOR MEDI-  
 8 CARE SUPPLEMENTAL POLICIES.—

9 “(1) PROMULGATION OF MODEL REGULA-  
 10 TION.—

11 “(A) NAIC MODEL REGULATION.—If,  
 12 within 9 months after the date of enactment of  
 13 the DrugGap Insurance for Seniors Act of  
 14 1999, the National Association of Insurance  
 15 Commissioners (in this subsection referred to as  
 16 the “NAIC”) changes the 1991 NAIC Model  
 17 Regulation (described in subsection (p)) to  
 18 incorporate—

19 “(i) limitations on the benefit pack-  
 20 ages that may be offered under a medicare  
 21 supplemental policy consistent with para-  
 22 graphs (2) and (3) of this subsection;

23 “(ii) an appropriate range of coverage  
 24 options for outpatient prescription drugs,  
 25 including at least a minimal level of cov-  
 26 erage under each benefit package;

1 “(iii) a deductible for outpatient pre-  
2 scription drugs that is uniform across each  
3 benefit package;

4 “(iv) uniform language and definitions  
5 to be used with respect to such benefits;

6 “(v) uniform format to be used in the  
7 policy with respect to such benefits; and

8 “(vi) other standards to meet the ad-  
9 ditional requirements imposed by the  
10 amendments made by the DrugGap Insur-  
11 ance for Seniors Act of 1999;

12 subsection (g)(2)(A) shall be applied in each  
13 State, effective for policies issued to policy hold-  
14 ers on and after the date specified in subpara-  
15 graph (C), as if the reference to the Model Reg-  
16 ulation adopted on June 6, 1979, were a ref-  
17 erence to the 1991 NAIC Model Regulation as  
18 changed under this subparagraph (such  
19 changed regulation referred to in this section as  
20 the ‘2000 NAIC Model Regulation’).

21 “(B) REGULATION BY THE SECRETARY.—  
22 If the NAIC does not make the changes in the  
23 1991 NAIC Model Regulation within the 9-  
24 month period specified in subparagraph (A), the  
25 Secretary shall promulgate, not later than 9

1 months after the end of such period, a regula-  
 2 tion and subsection (g)(2)(A) shall be applied in  
 3 each State, effective for policies issued to policy  
 4 holders on and after the date specified in sub-  
 5 paragraph (C), as if the reference to the Model  
 6 Regulation adopted on June 6, 1979, were a  
 7 reference to the 1991 NAIC Model Regulation  
 8 as changed by the Secretary under this sub-  
 9 paragraph (such changed regulation referred to  
 10 in this section as the ‘2000 Federal Regula-  
 11 tion’).

12 “(C) DATE SPECIFIED.—

13 “(i) IN GENERAL.—Subject to clause  
 14 (ii), the date specified in this subparagraph  
 15 for a State is the date the State adopts the  
 16 2000 NAIC Model Regulation or 2000  
 17 Federal Regulation or 1 year after the date  
 18 the NAIC or the Secretary first adopts  
 19 such standards, whichever is earlier.

20 “(ii) STATES REQUIRING REVISIONS  
 21 TO STATE LAW.—In the case of a State  
 22 which the Secretary identifies, in consulta-  
 23 tion with the NAIC, as—

24 “(I) requiring State legislation  
 25 (other than legislation appropriating

1 funds) in order for medicare supple-  
2 mental policies to meet the 2000  
3 NAIC Model Regulation or 2000 Fed-  
4 eral Regulation; but

5 “(II) having a legislature which  
6 is not scheduled to meet in 2001 in a  
7 legislative session in which such legis-  
8 lation may be considered;

9 the date specified in this subparagraph is  
10 the first day of the first calendar quarter  
11 beginning after the close of the first legis-  
12 lative session of the State legislature that  
13 begins on or after January 1, 2000. For  
14 purposes of the previous sentence, in the  
15 case of a State that has a 2-year legislative  
16 session, each year of such session shall be  
17 deemed to be a separate regular session of  
18 the State legislature.

19 “(D) CONSULTATION WITH WORKING  
20 GROUP.—In promulgating standards under this  
21 paragraph, the NAIC or Secretary shall consult  
22 with a working group composed of representa-  
23 tives of issuers of medicare supplemental poli-  
24 cies, consumer groups, medicare beneficiaries,  
25 and other qualified individuals. Such represent-

1           atives shall be selected in a manner so as to as-  
2           sure balanced representation among the inter-  
3           ested groups.

4           “(E) MODIFICATION OF STANDARDS IF  
5           MEDICARE BENEFITS CHANGE.—If benefits (in-  
6           cluding deductibles and coinsurance) under this  
7           title are changed and the Secretary determines,  
8           in consultation with the NAIC, that changes in  
9           the 2000 NAIC Model Regulation or 2000 Fed-  
10          eral Regulation are needed to reflect such  
11          changes, the preceding provisions of this para-  
12          graph shall apply to the modification of stand-  
13          ards previously established in the same manner  
14          as they applied to the original establishment of  
15          such standards.

16          “(2) CORE GROUP OF BENEFITS AND NUMBER  
17          OF BENEFIT PACKAGES.—The benefits under the  
18          2000 NAIC Model Regulation or 2000 Federal Reg-  
19          ulation shall provide—

20                 “(A) for such groups or packages of bene-  
21                 fits as may be appropriate taking into account  
22                 the considerations specified in paragraph (3)  
23                 and the requirements of the succeeding sub-  
24                 paragraphs;

1           “(B) for identification of a core group of  
2 basic benefits common to all policies other than  
3 the medicare supplemental policies described in  
4 paragraph (12)(B); and

5           “(C) that, subject to paragraph (4)(B), the  
6 total number of different benefit packages  
7 (counting the core group of basic benefits de-  
8 scribed in subparagraph (B) and each other  
9 combination of benefits that may be offered as  
10 a separate benefit package) that may be estab-  
11 lished in all the States and by all issuers shall  
12 not exceed 10 plus the 2 benefit packages de-  
13 scribed in paragraph (11) and the 3 policies de-  
14 scribed in paragraph (12)(B).

15           “(3) BALANCE OF OBJECTIVES.—The benefits  
16 under paragraph (2) shall, to the extent possible,  
17 balance the objectives of—

18           “(A) ensuring that medicare supplemental  
19 policies are affordable for beneficiaries under  
20 this title, and that the policies modernized  
21 under this subsection do not have premiums  
22 higher than the medicare supplemental policies  
23 available on the date of enactment of the  
24 DrugGap Insurance for Seniors Act of 1999;

1           “(B) facilitating comparisons among poli-  
2           cies;

3           “(C) avoiding adverse selection;

4           “(D) providing consumer choice;

5           “(E) providing market stability;

6           “(F) promoting competition;

7           “(G) including some drug coverage, how-  
8           ever limited, in each of the 10 benefit packages  
9           described in paragraph (2)(C); and

10           “(H) ensuring that beneficiaries under this  
11           title receive the benefit of prices for outpatient  
12           prescription drugs negotiated by issuers of  
13           medicare supplemental policies under this sec-  
14           tion.

15           “(4) STATES MAY OFFER NEW OR INNOVATIVE  
16           SUPPLEMENTAL BENEFITS.—

17           “(A) COMPLIANCE WITH APPLICABLE 2000  
18           NAIC MODEL REGULATION OR 2000 FEDERAL  
19           REGULATION REQUIRED.—

20           “(i) STATES.—Except as provided in  
21           subparagraph (B) or paragraph (6), no  
22           State with a regulatory program approved  
23           under subsection (b)(1) may provide for or  
24           permit the grouping of benefits (or lan-  
25           guage or format with respect to such bene-

1 fits) under a medicare supplemental policy  
2 unless such grouping meets the applicable  
3 2000 NAIC Model Regulation or 2000  
4 Federal Regulation.

5 “(ii) FEDERAL GOVERNMENT.—Ex-  
6 cept as provided in subparagraph (B), the  
7 Secretary may not provide for or permit  
8 the grouping of benefits (or language or  
9 format with respect to such benefits) under  
10 a medicare supplemental policy seeking ap-  
11 proval by the Secretary unless such group-  
12 ing meets the applicable 2000 NAIC Model  
13 Regulation or 2000 Federal Regulation.

14 “(B) ADDITIONAL BENEFITS.—The issuer  
15 of a medicare supplemental policy may offer the  
16 benefits described in subsection (p)(3)(B) under  
17 the circumstances described in such subsection  
18 as if each reference to ‘1991’ were a reference  
19 to ‘2000’.

20 “(5) STATES MAY NOT RESTRICT CORE BENE-  
21 FITS.—

22 “(A) MEDICARE SUPPLEMENTAL POLICIES  
23 SUBJECT TO STATE REGULATION.—Except as  
24 provided in subparagraph (B), this subsection  
25 shall not be construed as preventing a State

1 from restricting the groups of benefits that may  
2 be offered in medicare supplemental policies in  
3 the State.

4 “(B) MUST MAKE CORE BENEFITS AVAIL-  
5 ABLE.—A State with a regulatory program ap-  
6 proved under subsection (b)(1) may not restrict  
7 under subparagraph (A) the offering of a medi-  
8 care supplemental policy consisting only of the  
9 core group of benefits described in paragraph  
10 (2)(B).

11 “(6) STATE ALTERNATIVE SIMPLIFICATION  
12 PROGRAMS.—The Secretary may waive the applica-  
13 tion of standards described in clauses (i) through  
14 (vi) of paragraph (1)(A) in those States that on the  
15 date of enactment of the DrugGap Insurance for  
16 Seniors Act of 1999 had in place an alternative sim-  
17 plification program.

18 “(7) DISCOUNTS FOR ITEMS AND SERVICES  
19 NOT COVERED UNDER MEDICARE SUPPLEMENTAL  
20 POLICIES.—This subsection shall not be construed  
21 as preventing an issuer of a medicare supplemental  
22 policy who otherwise meets the requirements of this  
23 section from providing, through an arrangement  
24 with a vendor, for discounts from that vendor to pol-  
25 icy holders or certificate holders for the purchase of

1 items or services not covered under its medicare sup-  
2 plemental policies or under this title, including the  
3 issuance of drug discount cards.

4 “(8) CIVIL PENALTY FOR VIOLATION OF THE  
5 MODEL REGULATION.—Except as provided in para-  
6 graph (10), any person who sells or issues a medi-  
7 care supplemental policy, on and after the effective  
8 date specified in paragraph (1)(C), in violation of  
9 the applicable 2000 NAIC Model Regulation or 2000  
10 Federal Regulation insofar as such regulation relates  
11 to the requirements of subsection (o) or (q) or  
12 clauses (i) through (vi) of paragraph (1)(A) is sub-  
13 ject to a civil money penalty of not to exceed  
14 \$25,000 (or \$15,000 in the case of a seller who is  
15 not an issuer of a policy) for each such violation.  
16 The provisions of section 1128A (other than the  
17 first sentence of subsection (a) and other than sub-  
18 section (b)) shall apply to a civil money penalty  
19 under the previous sentence in the same manner as  
20 such provisions apply to a penalty or proceeding  
21 under section 1128A(a).

22 “(9) REQUIREMENTS OF SELLERS.—

23 “(A) CORE BENEFIT PACKAGE.—Anyone  
24 who sells a medicare supplemental policy to an  
25 individual shall make available for sale to the

1 individual a medicare supplemental policy with  
2 only the core group of basic benefits (described  
3 in paragraph (2)(B)).

4 “(B) OUTLINE OF COVERAGE.—Anyone  
5 who sells a medicare supplemental policy to an  
6 individual shall provide the individual, before  
7 the sale of the policy, an outline of coverage  
8 which describes the benefits under the policy.  
9 Such outline shall be on a standard form ap-  
10 proved by the State regulatory program or the  
11 Secretary (as the case may be) consistent with  
12 the 2000 NAIC Model Regulation or 2000 Fed-  
13 eral Regulation under this subsection.

14 “(C) PENALTIES.—Whoever sells a medi-  
15 care supplemental policy in violation of this  
16 paragraph is subject to a civil money penalty of  
17 not to exceed \$25,000 (or \$15,000 in the case  
18 of a seller who is not the issuer of the policy)  
19 for each such violation. The provisions of sec-  
20 tion 1128A (other than the first sentence of  
21 subsection (a) and other than subsection (b))  
22 shall apply to a civil money penalty under the  
23 previous sentence in the same manner as such  
24 provisions apply to a penalty or proceeding  
25 under section 1128A(a).

1           “(D) EFFECTIVE DATE.—Subject to para-  
2           graph (10), this paragraph shall apply to sales  
3           of policies occurring on or after the effective  
4           date specified in paragraph (1)(C).

5           “(10) SAFE HARBOR FOR SELLERS.—No pen-  
6           alty may be imposed under paragraph (8) or (9) in  
7           the case of a seller who is not the issuer of a policy  
8           until the Secretary has published a list of the groups  
9           of benefit packages that may be sold or issued con-  
10          sistent with paragraph (1)(A)(i).

11          “(11) ADDITION OF HIGH DEDUCTIBLE MEDI-  
12          CARE SUPPLEMENTAL POLICIES.—For purposes of  
13          paragraph (2), the benefit packages described in this  
14          paragraph are the benefit packages modernized  
15          under this subsection that the Secretary determines  
16          are most comparable to the benefit packages de-  
17          scribed in subsection (p)(11).

18          “(12) DRUGGAP MEDICARE SUPPLEMENTAL  
19          POLICIES.—

20                 “(A) ESTABLISHMENT OF DRUG-ONLY  
21                 MEDICARE SUPPLEMENTAL POLICIES.—

22                         “(i) IN GENERAL.—There are estab-  
23                         lished 3 benefit packages, consistent with  
24                         the benefit packages described in subpara-  
25                         graph (B), that—

1 “(I) consist of only outpatient  
2 prescription drug benefits;

3 “(II) may be designed to incor-  
4 porate the utilization management  
5 techniques described in subparagraph  
6 (C);

7 “(III) do not include benefits for  
8 prescription drugs otherwise available  
9 under part A or B; and

10 “(IV) do not include benefits for  
11 any prescription drug excluded by the  
12 State in which the medicare supple-  
13 mental policy is issued or sold under  
14 section 1927(d).

15 “(ii) DEFINITION.—In this section,  
16 the term ‘DrugGap medicare supplemental  
17 policy’ means a medicare supplemental pol-  
18 icy (as defined in subsection (g)(1)) that  
19 has 1 of the benefit packages described in  
20 subparagraph (B).

21 “(B) BENEFIT PACKAGES DESCRIBED.—  
22 The benefit packages for DrugGap medicare  
23 supplemental policies described in this para-  
24 graph are as follows:

1           “(i) STANDARD DRUGGAP BENEFIT  
2           PACKAGES.—

3           “(I) STANDARD DRUGGAP.—A  
4           Standard DrugGap medicare supple-  
5           mental policy that provides a deduct-  
6           ible not to exceed \$250, coinsurance  
7           not to exceed 20 percent, and a  
8           \$5,000 maximum benefit.

9           “(II) LOW-COST STANDARD  
10          DRUGGAP.—A Low-Cost Standard  
11          DrugGap medicare supplemental pol-  
12          icy that provides a deductible not to  
13          exceed \$750, coinsurance not to ex-  
14          ceed 30 percent, and a \$5,000 max-  
15          imum benefit.

16          “(ii) STOP-LOSS DRUGGAP BENEFIT  
17          PACKAGE.—A Stop-Loss DrugGap medi-  
18          care supplemental policy that provides a  
19          stop-loss coverage benefit that limits the  
20          application of any beneficiary cost-sharing  
21          during a year after the beneficiary incurs  
22          out-of-pocket covered expenditures in ex-  
23          cess of \$5,000, or, in the case that the  
24          beneficiary owns a DrugGap medicare sup-  
25          plemental policy described in clause (i),

1 such beneficiary reaches the maximum  
2 benefit under such policy.

3 “(iii) MAXIMUM BENEFIT DEFINED.—

4 In this paragraph, the term ‘maximum  
5 benefit’ means the total amount paid for  
6 covered outpatient prescription drugs, in-  
7 cluding any amounts paid by the issuer of  
8 the DrugGap medicare supplemental policy  
9 and any cost-sharing paid by the policy-  
10 holder.

11 “(C) USE OF UTILIZATION MANAGEMENT  
12 TECHNIQUES.—

13 “(i) FORMULARIES.—An issuer may  
14 use a formulary to contain costs under any  
15 benefit package established under subpara-  
16 graph (A)(i) only if the issuer—

17 “(I) includes in the formulary at  
18 least 1 drug from each therapeutic  
19 class and provides at least 1 generic  
20 equivalent, if available; and

21 “(II) provides for coverage of  
22 otherwise covered nonformulary drugs  
23 when a nonformulary alternative is  
24 medically necessary and appropriate.

1                   “(ii) OTHER UTILIZATION MANAGE-  
 2                   MENT TECHNIQUES.—Nothing in this part  
 3                   shall be construed as preventing an issuer  
 4                   offering DrugGap medicare supplemental  
 5                   policies from using reasonable utilization  
 6                   management techniques, including generic  
 7                   drug substitution, consistent with applica-  
 8                   ble law.”.

9           (b) DRUGGAP MEDIGAP POLICIES DO NOT DUPLI-  
 10          CATE OTHER MEDIGAP POLICIES.—Section 1882(d)(3) of  
 11          the Social Security Act (42 U.S.C. 1395ss(d)(3)) is  
 12          amended—

13               (1) in subparagraph (A), by adding at the end  
 14               the following:

15               “(ix) Nothing in this subparagraph shall be construed  
 16               as preventing the sale of a DrugGap policy to an indi-  
 17               vidual, provided that the sale is of a DrugGap policy that  
 18               does not duplicate any health benefits under a medicare  
 19               supplemental policy owned by the individual.”;

20               (2) in subparagraph (B)(ii)(I), by inserting  
 21               “and one DrugGap medicare supplemental policy”  
 22               before the comma; and

23               (3) in subparagraph (B)(iii)—

24                       (A) in subclause (I), by striking “(II) and  
 25                       (III)” and inserting “(II), (III), and (IV)”;

1 (B) by redesignating subclause (III) as  
2 subclause (IV); and

3 (C) by inserting after subclause (II) the  
4 following:

5 “(III) If the statement required by clause (i) is ob-  
6 tained and indicates that the individual is enrolled in 1  
7 or more medicare supplemental policies, the sale of a  
8 DrugGap policy is not in violation of clause (i) if such  
9 DrugGap policy does not duplicate health benefits under  
10 any policy in which the individual is enrolled.”.

11 (c) ENROLLMENT IN CASE OF INVOLUNTARY TERMI-  
12 NATIONS OF COVERAGE.—Section 1882(s)(3)(C)(i) of the  
13 Social Security Act (42 U.S.C. 1395ss(s)(3)(C)(i)) is  
14 amended by striking “under subsection (p)(2)” and insert-  
15 ing “under subsection (v)(2), a Standard DrugGap medi-  
16 care supplemental policy under the standards established  
17 under subsection (v)(12)(B)(i), and a Stop-Loss DrugGap  
18 medicare supplemental policy under the standards estab-  
19 lished under subsection (v)(12)(B)(ii)”.

20 (d) SPECIAL ENROLLMENT PERIOD.—Section  
21 1882(n) of the Social Security Act (42 U.S.C. 1395ss(n))  
22 is amended by adding at the end the following:

23 “(7)(A) No medicare supplemental policy of the  
24 issuer shall be deemed to meet the standards in subsection  
25 (c) unless the issuer—

1           “(i) provides written notice, within a 60-day pe-  
2           riod specified in the modernization of the medicare  
3           supplemental policies under subsection (v), to the  
4           policyholder or certificate holder (at the most recent  
5           available address) of the offer described in clause  
6           (ii); and

7           “(ii) offers the individual under the terms de-  
8           scribed in subparagraph (B), during a period of 180  
9           days beginning on the date specified in subpara-  
10          graph (C), institution of coverage effective as of the  
11          date specified in the modernization described in  
12          clause (i) for such purpose, for any policy described  
13          under subsection (v).

14          “(B) The terms described under this subparagraph  
15          are terms which do not—

16                 “(i) deny or condition the issuance or effective-  
17                 ness of a medicare supplemental policy described in  
18                 subparagraph (A)(ii) that is offered and is available  
19                 for issuance to new enrollees by such issuer;

20                 “(ii) discriminate in the pricing of such policy,  
21                 because of health status, claims experience, receipt  
22                 of health care, or medical condition; or

23                 “(iii) impose an exclusion of benefits based on  
24                 a preexisting condition under such policy.

1       “(C) The date specified in this subparagraph for a  
2 policy issued in a State is such date as the Secretary, in  
3 consultation with the NAIC, specifies (taking into account  
4 the method used under paragraph (4) for establishing a  
5 date under this subsection).”.

6       (e) CONFORMING AMENDMENTS.—Section 1882 of  
7 the Social Security Act (42 U.S.C. 1395ss) is amended—

8           (1) in subsection (a)(2)—

9               (A) in the matter preceding subparagraph

10           (A), by striking “(p)” and inserting “(v)”;

11               (B) in subparagraph (A)—

12                   (i) by striking “1991” each place it  
13           appears and inserting “2000”; and

14                   (ii) by striking “(p)” and inserting  
15           “(v)”;

16               (C) in the matter following subparagraph

17           (B), by striking “(p)” and inserting “(v)”;

18           (2) in subsection (o)—

19               (A) in paragraph (1), by striking “(p)”  
20           and inserting “(v)”;

21               (B) in paragraph (2), by striking “(p)”  
22           and inserting “(v)”;

23           (3) in subsection (r)—

24               (A) in paragraph (1)—

1 (i) in the matter preceding subpara-  
 2 graph (A), by striking “(p)” and inserting  
 3 “(v)”;

4 (ii) in the matter following subpara-  
 5 graph (B), by striking “(p)” and inserting  
 6 “(v)”;

7 (B) in paragraph (2)(A)—

8 (i) by striking “(p)” and inserting  
 9 “(v)”;

10 (ii) by striking “the date specified in  
 11 section 171(m)(4) of the Social Security  
 12 Act Amendments of 1994” and inserting  
 13 “the date of enactment of the DrugGap In-  
 14 surance for Seniors Act of 1999”.

15 **SEC. 4. ASSISTANCE TO QUALIFIED LOW-INCOME MEDI-**  
 16 **CARE BENEFICIARIES.**

17 (a) IN GENERAL.—Part B of title XVIII of the Social  
 18 Security Act (42 U.S.C. 1395j et seq.) is amended by add-  
 19 ing at the end the following:

20 **“SEC. 1849. ASSISTANCE TO QUALIFIED LOW-INCOME MEDI-**  
 21 **CARE BENEFICIARIES.**

22 “(a) QUALIFIED LOW-INCOME MEDICARE BENE-  
 23 FICIARY DEFINED.—For purposes of this part, the term  
 24 ‘qualified low-income medicare beneficiary’ means an  
 25 individual—

1           “(1) who is—

2                   “(A) entitled to benefits under part A;

3                   “(B) enrolled under this part; and

4                   “(C) who does not have coverage for out-  
5           patient prescription drugs through enrollment  
6           in a Medicare+Choice plan offered by a  
7           Medicare+Choice organization under part C or  
8           in a group health plan;

9           “(2) who would be eligible for medical assist-  
10          ance under title XIX but for the fact that the indi-  
11          vidual’s income exceeds the income level (expressed  
12          as a percentage of the poverty line) established by  
13          the State for eligibility for medical assistance under  
14          such title, including at least the care and services  
15          listed in paragraphs (1) through (5), (17), and (21)  
16          of section 1905(a), but does not exceed the lesser  
17          of—

18                   “(A) 50 percentage points above such in-  
19          come level; or

20                   “(B) 200 percent of the poverty line; and

21          “(3) who is enrolled in—

22                   “(A) a Standard DrugGap medicare sup-  
23          plemental policy and a Stop-Loss DrugGap  
24          medicare supplemental policy as such policies

1 are described in clauses (i)(I) and (ii) of section  
2 1882(v)(12)(B), respectively; or

3 “(B) a Low-Cost Standard DrugGap medi-  
4 care supplemental policy and a Stop-Loss  
5 DrugGap medicare supplemental policy as such  
6 policies are described in clauses (i)(II) and (ii)  
7 of section 1882(v)(12)(B), respectively.

8 “(b) PROGRAM ADMINISTERED BY THE STATES.—

9 “(1) IN GENERAL.—The Secretary shall estab-  
10 lish an arrangement with each State (as defined  
11 under section 1861(x)) under which the State per-  
12 forms the functions described in paragraphs (2)  
13 through (4).

14 “(2) ANNUAL ELIGIBILITY.—The State shall  
15 determine whether a beneficiary under this title in  
16 the State is a qualified low-income medicare bene-  
17 ficiary. A determination that such an individual is a  
18 qualified low-income medicare beneficiary shall re-  
19 main valid for a period of 12 months but is condi-  
20 tioned upon continuing enrollment in medicare sup-  
21 plemental policies described in subsection (a)(4).

22 “(3) COMPUTATION OF STATE WEIGHTED AV-  
23 ERAGE PREMIUM FOR STANDARD DRUGGAP AND  
24 STOP-LOSS DRUGGAP MEDICARE SUPPLEMENTAL  
25 POLICIES.—For each year, the State shall compute

1 a State weighted average premium equal to the  
 2 weighted average of the premiums for medicare sup-  
 3 plemental policies described in clause (i)(I) of section  
 4 1882(v)(12)(B) and the medicare supplemental poli-  
 5 cies described in clause (ii) of such section for the  
 6 State, with the weight for each medicare supple-  
 7 mental policy being equal to the average number of  
 8 beneficiaries under this title enrolled under such pol-  
 9 icy in the previous year. In the initial year that such  
 10 medicare supplemental policies are available, the  
 11 State shall estimate the State weighted average pre-  
 12 mium for each type of policy.

13 “(4) PAYMENT BY STATES ON BEHALF OF  
 14 QUALIFIED LOW-INCOME MEDICARE BENE-  
 15 FICIARIES.—The State shall provide for payment to  
 16 the appropriate entity on behalf of a qualified low-  
 17 income medicare beneficiary for a year in an amount  
 18 equal to—

19 “(A) for the medicare supplemental policy  
 20 described under clause (i) of section  
 21 1882(v)(12)(B) in which such beneficiary is en-  
 22 rolled, the lesser of—

23 “(i) the amount of the State weighted  
 24 average premium (as computed under

1 paragraph (3)) for the policies described  
2 under subclause (I) of such clause; or

3 “(ii) the full quoted premium for the  
4 policy;

5 “(B) for the medicare supplemental policy  
6 described under clause (ii) of section  
7 1882(v)(12)(B) in which such beneficiary is en-  
8 rolled, the lesser of—

9 “(i) the amount of the State weighted  
10 average premium (as computed under  
11 paragraph (3)) for the policies described  
12 under such clause; or

13 “(ii) the full quoted premium for the  
14 policy; and

15 “(C) such beneficiary out-of-pocket ex-  
16 penses related to the supplemental benefits pro-  
17 vided under the policies described in subpara-  
18 graphs (A) and (B) as the State determines is  
19 appropriate.

20 “(c) PAYMENTS TO STATES.—

21 “(1) REIMBURSEMENT FROM FEDERAL SUP-  
22 PLEMENTARY MEDICAL INSURANCE TRUST FUND.—  
23 Each calendar quarter in a fiscal year, the Secretary  
24 shall pay to each State from the Federal Supple-  
25 mentary Medical Insurance Trust Fund under sec-

1       tion 1841 an amount equal to the amount paid by  
2       the State under subsection (b)(4).

3               “(2) EXCLUSION OF ADDITIONAL PART B COSTS  
4       FROM DETERMINATION OF PART B PREMIUM.—In  
5       estimating the benefits and administrative costs that  
6       will be payable from the Federal Supplementary  
7       Medical Insurance Trust Fund for a year for pur-  
8       poses of determining the monthly premium rate  
9       under section 1839(a)(3), the Secretary shall exclude  
10      an estimate of any benefits and administrative costs  
11      attributable to the application of this section.

12              “(3) CONSTRUCTION RELATIVE TO OTHER BEN-  
13      EFITS.—Nothing in this section shall be construed  
14      as requiring a State, under its plan under title XIX,  
15      to be responsible for any portion of the subsidy or  
16      beneficiary cost-sharing provided under this section  
17      to qualified low-income medicare beneficiaries.

18              “(d) MAINTENANCE OF STATE EFFORT REQUIRE-  
19      MENT.—In the case of any State in which the income level  
20      (expressed as a percentage of the poverty line) established  
21      by the State for eligibility for medical assistance under  
22      title XIX (that includes at least the care and services list-  
23      ed in paragraphs (1) through (5), (17), and (21) of section  
24      1905(a)) is less than 150 percent of the poverty line appli-

1 cable to a family of the size involved in a calendar quarter  
2 in a fiscal year—

3 “(1) no payment may be made to such State  
4 under section 1849(c) for a calendar quarter in a  
5 fiscal year unless the State demonstrates to the sat-  
6 isfaction of the Secretary that the expenditures of  
7 the State for any State-funded prescription drug  
8 program for which individuals entitled to benefits  
9 under this section are eligible during the fiscal year  
10 is not less than the level of such expenditures for  
11 fiscal year 1999; and

12 “(2) payments shall not be made under this  
13 section for coverage of prescription drugs to the ex-  
14 tent that—

15 “(A) payment is made under such a pro-  
16 gram; or

17 “(B) the Secretary determines payment  
18 would be made under such a program as in ef-  
19 fect on the date of enactment of the DrugGap  
20 Insurance for Seniors Act of 1999.

21 “(e) POVERTY LINE DEFINED.—The term ‘poverty  
22 line’ has the meaning given such term in section 673(2)  
23 of the Community Services Block Grant Act (42 U.S.C.  
24 9902(2)), including any revision required by such sec-  
25 tion.”.

1 (b) CONFORMING AMENDMENT.—Section 1839(a)(3)  
 2 of the Social Security Act (42 U.S.C. 1395r(a)(3)), as  
 3 amended by section 5101(e) of the Tax and Trade Relief  
 4 Extension Act of 1998 (contained in division J of Public  
 5 Law 105–277), is amended by striking “except as pro-  
 6 vided in subsection (g)” and inserting “except as provided  
 7 in subsection (g) or section 1849(d)”.

8 **SEC. 5. GRANDFATHERING OF CURRENT MEDIGAP EN-**  
 9 **ROLLEES.**

10 (a) IN GENERAL.—The amendments made by this  
 11 Act shall take effect on the date of enactment of this Act,  
 12 and shall apply to medicare supplemental policies issued  
 13 or sold after the date specified in subsection (b), but shall  
 14 not apply to the renewal of medicare supplemental policies  
 15 that are in existence on such date.

16 (b) DATE SPECIFIED.—The date specified in this  
 17 subsection for each State is the date specified under sec-  
 18 tion 1882(n)(7)(C) of the Social Security Act (42 U.S.C.  
 19 1395ss(n)(7)(C)) (as added by section 3(d) of this Act).

20 **SEC. 6. HEALTH INSURANCE INFORMATION, COUNSELING,**  
 21 **AND ASSISTANCE GRANTS.**

22 (a) IN GENERAL.—Section 4360(b)(2)(A)(ii) of the  
 23 Omnibus Budget Reconciliation Act of 1990 (42 U.S.C.  
 24 1395b–4(b)(2)(A)(ii)) is amended by striking “and infor-  
 25 mation” and inserting “, providing specific information re-

1 garding any DrugGap benefit medicare supplemental pol-  
2 icy described under section 1882(v) of the Social Security  
3 Act (42 U.S.C. 1395ss(v)), and information”.

4 (b) AUTHORIZATION OF APPROPRIATIONS.—In addi-  
5 tion to any amounts otherwise appropriated, there are au-  
6 thorized to be appropriated \$50,000,000 for each fiscal  
7 year, beginning with the first year in which a DrugGap  
8 medicare supplemental policy described in section  
9 1882(v)(12) is available, for the purpose of carrying out  
10 the provisions of section 4360 of the Omnibus Budget  
11 Reconciliation Act of 1990 (as amended by subsection  
12 (a)).

13 **SEC. 7. NAIC STUDY AND REPORT.**

14 (a) STUDY.—The Secretary of Health and Human  
15 Services shall contract with the National Association of  
16 Insurance Commissioners (referred to in this section as  
17 the “NAIC”) to conduct a study of medicare supplemental  
18 policies offered under section 1882 of the Social Security  
19 Act (42 U.S.C. 1395ss) in order to identify—

20 (1) areas that are the cause of increasing medi-  
21 care supplemental insurance claims costs (such as  
22 outpatient expenses) that affect the affordability of  
23 medicare supplemental policies;

24 (2) changes to Federal law (if any) required to  
25 address the issues identified under paragraph (1) to

1 make medicare supplemental policies more afford-  
2 able for beneficiaries under the medicare program  
3 under title XVIII of the Social Security Act (42  
4 U.S.C. 1395 et seq.); and

5 (3) methods of encouraging additional issuers  
6 to offer such policies and to reduce the cost of pre-  
7 miums for such policies.

8 (b) REPORT.—Not later than November 1, 2001, the  
9 NAIC shall submit a report to the Secretary of Health  
10 and Human Services on the study conducted under sub-  
11 section (a) that contains a detailed statement of the find-  
12 ings and conclusions of the NAIC together with rec-  
13 ommendations for such legislation and administrative ac-  
14 tions as the NAIC considers appropriate.

15 (c) TRANSMISSION TO CONGRESS.—Not later than  
16 January 1, 2002, the Secretary of Health and Human  
17 Services shall transmit the report submitted under sub-  
18 section (b) to Congress together with recommendations for  
19 such legislation and administrative actions as the Sec-  
20 retary considers appropriate.

○